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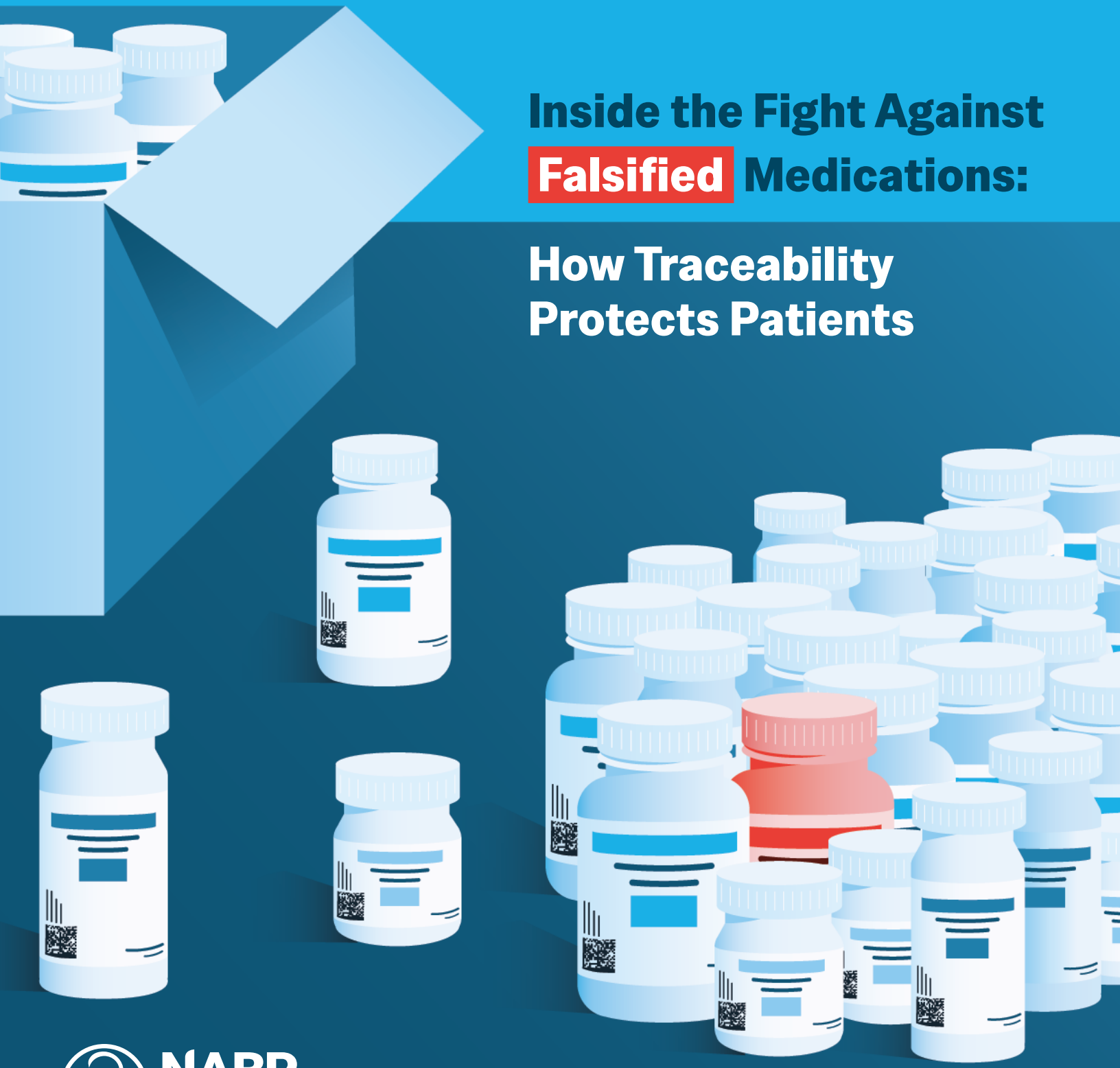
iNNOVATiONS

Inside the Fight Against Falsified Medications:

How Traceability Protects Patients



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INNOVATIONS

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NABP Mission Statement
NABP is the independent, international, and impartial Association that assists its member boards in protecting the public health.

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NABP
National Association of Boards of Pharmacy

Jeffrey J. Mesaros, PharmD, JD, RPh
NABP Chairperson

Fellow Members,

As we close the doors on a year of significant change and look ahead to 2026, I'm reminded that our duty as regulators is not just to respond to current challenges, but to anticipate those that lie over the horizon. We have all seen how pharmacy practice and regulation are constantly reshaped by innovation, and NABP is committed to ensuring the boards of pharmacy remain positioned to address whatever comes their way.

This issue of *Innovations* highlights ongoing efforts to secure the drug supply chain. While the cover story focuses on broader efforts, I'm particularly excited by the promise of Pulse by NABP™, and this article helps demonstrate how the product verification service may help improve regulators' access to vital information when investigating suspected illegitimate or substandard medications.

This issue also examines vital regulatory frontiers that I've heard many of you discussing over the last few years. For example, the Policy Perspectives column provides an essential viewpoint on med spa regulations, while we also cover "just culture" implementation and reducing recidivism through education.

In addition, this issue includes information on the 122nd NABP Annual Meeting, which will be held May 12-15, 2026, in Boston, MA. Registration for the meeting is now open, with early registration rates in place until the end of February. Among other vital functions, the Annual Meeting serves as a forum for strategizing the future of pharmacy regulation, and your insights are crucial to the Association's continued success.

I look forward to seeing you there and continuing to champion public health through strong, proactive collaboration and a focus on innovation. ●

Sincerely,

Jeffrey J. Mesaros, PharmD, JD, RPh
NABP Chairperson

Injecting Clarity: The State of Medical Spa Regulation in the US

Listen | 11:11

John B. Hertig, MS, PharmD, CPPS, FASHP, FFIP, Hertig Healthcare Advising, LLC

The medical spa, or "med spa," industry is booming in the United States. Spurred by a demand for minimally invasive procedures, intravenous (IV) hydration, wellness and cosmetic treatments, and weight loss medication, med spas are now found everywhere, from strip malls to upscale hotels. For boards of pharmacy, this is a trend that demands attention, as med spas are increasingly becoming sites where prescription drugs are being stored, administered, dispensed, distributed, or otherwise used in connection with providing services. Med spas present a growing regulatory challenge for boards of pharmacy, as these businesses combine the handling of prescription drugs with clinical services, yet regulatory oversight is fragmented and inconsistent across states. This article exposes these gaps and the associated risks to patient safety.

What Laws Are (and Are Not) in Place Regarding Med Spa Practices

In 46 states, med spa physical facilities are not required to obtain a specific med spa license or registration. Rather, the individual health care professionals who deliver the services (ie, the nurse practitioners, advanced practice registered nurses [APRNs], physician assistants [PAs], and physicians) are regulated.

Four states have taken a more active role in regulating med spas at the facility level. Mississippi's State Board of Medical Licensure, for instance, requires registration for any practice that advertises weight loss services, categorizing them as bariatric or weight management practices. Tennessee's Board of Medical Examiners and Board of Osteopathic Examination mandate registration for med spas that offer "cosmetic medical services." In addition, Utah's Division of Consumer Protection requires registration of "health spas," though, notably, physician-owned practices are excluded from this requirement.

Ohio stands apart by regulating med spas as "terminal distributors of dangerous drugs," a designation that places oversight directly under the Ohio Board of Pharmacy. Under Ohio law, this applies to any person or entity engaged in the sale of dangerous drugs at retail or any person (other than a wholesale distributor or pharmacist) who has possession, custody, or control of dangerous drugs for any purpose other than for their own use and consumption. In Ohio, the term "dangerous drug" is defined broadly to encompass any prescription medication. As a result, med spas offering injectable treatments or other prescription-based procedures must be licensed as terminal distributors and adhere to the Board of Pharmacy's rules regarding drug procurement, storage, and administration.

This general lack of facility-level accountability, coupled with inconsistent regulatory oversight across states, means prescription drugs may be stored, administered, dispensed, distributed, or otherwise used in med spas without the safety controls required in licensed facilities. As a result, oversight and safety standards vary significantly, leaving patients at risk, unaware of this patchwork of safety standards and regulatory oversight.

Who Can Provide Med Spa Services?

The range of professionals delivering care in med spas is broad, including physicians, PAs, APRNs, and aestheticians. However, state law defines which types of procedures each provider may perform and sets specific requirements for supervision and delegation when a provider's authority is limited. The degree of autonomy and supervision required varies dramatically from state to state.

In 30 states, APRNs are empowered to prescribe and administer non-controlled substances independently. Alaska is one such state where APRNs may operate without physician involvement. In 13 states, APRNs must practice under physician supervision or through collaborative agreements, as in Louisiana. Meanwhile, eight states offer a path to independent practice for APRNs after completion of required clinical hours and continuing education.

Practically, in many med spa settings, delegation practices are being stretched to the limits of what the law allows. Depending on the state, personnel are sometimes permitted to perform services under the nominal "supervision" of a physician who may not be physically present, actively involved, or even regularly on site. In some cases, the supervising provider's role is limited to signing standing orders or providing oversight from a distance, often across multiple locations.

This practice raises significant patient safety concerns. Delegating procedures involving prescription products – particularly compounded sterile preparations – to staff undermines safeguards intended to protect patients, resulting in diffused accountability and less opportunities to identify unsafe practices.

For boards of pharmacy, these blurred lines between professional authority and delegation underscore the importance of clear, enforceable supervision standards for a med spa that stores, administers, dispenses, distributes, or otherwise uses prescription medication in connection with providing services. Strengthening these expectations is essential to ensuring patient safety and maintaining public trust in these increasingly common health care environments.

Which States Are Considering New Regulations for Med Spas?

Although most states have yet to adopt a comprehensive med spa regulatory framework, four are taking meaningful steps toward enhanced oversight. Colorado, for one, recently enacted legislation requiring providers to disclose when the provision of

medical-aesthetic services is delegated to an unlicensed individual. Nevada has passed a law that allows physicians, PAs, or APRNs to use space in a cosmetology establishment to provide health care services. Rhode Island has defined cosmetic medical procedures in law, specifying supervision requirements and scope of practice for different clinicians.

In 2025, Texas passed "Jenifer's Law" addressing IV therapy administered outside physician offices or licensed facilities. While early drafts proposed sweeping med spa reforms, the final version targeted IV hydration practices, recognizing the heightened patient safety risks related to sterile injectable compounding. Although glucagon-like peptide-1 (GLP-1) compounded products are also sterile injectables, they were not subject to this safety reform.

In addition to legislation, 18 states have issued agency guidance or formed working groups related to the operations of med spas, including guidance related to licensure, scope of practice, and ownership. For example, Alaska's working group includes tri-regulator collaborations between medical, nursing, and pharmacy focused on clarifying licensing and considering whether and how services such as prescribing, dispensing of medications, and compounding can be performed safely outside a traditional medical setting.

These developments mark a growing recognition that med spas are evolving into health care delivery sites where prescription products are administered to patients and, thus, warrant oversight comparable to other clinical settings.

IV Hydration Therapy: A Growing Area of Regulatory Focus and Indication of Things to Come

IV hydration therapy has become an increasingly common offering in med spas. Unlike traditional topical spa treatments, IV hydration involves the intravenous administration of sterile fluids, vitamins, and nutrients, often through compounded formulations. Because these products are infused directly into the bloodstream, they carry significant risks of contamination, dosing errors, and adverse reactions.

Recognizing these concerns, 35 states have issued statutes, regulations, or policy statements specific to IV hydration therapy. For example, in South Carolina, the Boards of Medical Examiners, Pharmacy, and Nursing jointly affirmed that IV therapy involves the practice of medicine, pharmacy, and nursing, each requiring appropriate licensure. Similarly, the California State Board of Pharmacy has emphasized that preparing IV mixtures constitutes sterile compounding and must be performed by trained personnel under compliant environmental conditions.

While IV hydration in med spas stimulated growth in the business model, demand for personalized GLP-1 products is now also driving the business. The regulatory rationale for increased scrutiny over IV hydration in med spas seems even stronger when applied to GLP-1s, given the risk profile of these more complex drugs. Boards of pharmacy are uniquely positioned to ensure that sterile injectable practices in med spas meet sterile compounding standards, proper storage requirements, and adequate clinical supervision to safeguard patients in this rapidly growing area of med spa practice.

Med Spas Have Been Linked to Dangerous and Illegal Practices

The risks associated with compounding medications in med spas are not theoretical. In Tennessee, a woman was arrested for manufacturing counterfeit weight-loss drugs in a makeshift home laboratory, ultimately supplying these unapproved and potentially contaminated medications to two local med spas. Similar concerns have surfaced in other states. Legal actions against two med spas, Thrive Health and Wellness, LLC, (Thrive Health Solutions) in Colorado and Premier Weight Loss in Indiana, uncovered different sterility failures: Thrive Health Solutions' compounded tirzepatide products were alleged to contain hazardous bacteria, while Premier Weight Loss products were said to have been repackaged in nonsterile conditions. These incidents highlight the critical need for boards of pharmacy to provide direct oversight of compounding practices in med spas, ensuring that medications are prepared, stored, and dispensed according to rigorous safety standards to prevent contaminated, incorrectly dosed, or counterfeit drugs from reaching patients and causing harm.

Looking Ahead: Themes in Policy and Regulations on the Horizon

The med spa industry shows no signs of slowing down. For boards of pharmacy and other health care regulators, the question is not whether med spas should be regulated, but how best to regulate them to ensure patient safety. Legislators and regulators may need to:

1. Clarify when med spa services become the practice of pharmacy, such that the facility and staff are regulated by the board of pharmacy.
2. Create facility-level regulation (such as licensure or registration) for med spas, such that for settings in which prescription medications are stored, administered, dispensed, distributed, or otherwise used, the medications meet the same standards as in any other health care setting.

Concurrently, boards of pharmacy will be expected to coordinate oversight, inspection, and investigations with nursing and medical regulators. Building a coordinated framework will help close safety gaps and prevent inconsistent oversight, improving patient safety. ●

This article was written by John B. Hertig, MS, PharmD, CPPS, FASHP, FFIP, founder of Hertig Healthcare Advising, LLC, on behalf of Faegre Drinker Biddle & Reath LLP. Please note, the opinions and views expressed by Hertig Healthcare Advising do not necessarily reflect the official views, opinions, or policies of NABP or any member board, unless expressly stated.

Inside the Fight Against Falsified Medications:

How Traceability Protects Patients

Listen | 10:08

Keeping the prescription drug supply chain secure is essential for ensuring patient safety.

However, the immense scale and complexity of the global supply chain have made it a persistent target for criminal organizations. The fight against substandard and falsified medications demands constant innovation and adaptation. As counterfeit methods evolve, so must the strategies used to detect and prevent them, requiring increasing collaboration across the supply chain to protect patients.

Why Drug Supply Chain Security Matters

Even in the United States, a market experts consider among the safest in the world, the prescription drug supply chain has been compromised by several high-profile schemes related to brand medications in recent years. One case uncovered in 2021 and 2022 involved selling counterfeit HIV medications to pharmacies, which in turn dispensed falsified medication bottles to patients. Investigators discovered that accused distributors of fraudulent products disguised the medications as legitimate Biktarvy® and Descovy®, ultimately trafficking over $250 million in fake drugs, disseminated to hundreds of independent pharmacies across 36 states. The ensuing harm to patients and the erosion of trust underscored the urgent need for stronger safeguards and a more transparent system.

These incidents are not isolated; falsified and diverted products have surfaced across multiple drug classes. From oncology therapies and cosmetic injectables to high-demand chronic care medications, these incidents reveal the breadth of vulnerabilities within the supply chain.

Today, the nature of the threat is shifting. The high demand for products such as the popular glucagon-like peptide-1 drugs used for weight loss and diabetes management (notably, Ozempic® and Wegovy®) has been met with a surge of falsified and substandard versions being offered to both pharmacies and consumers at discounted prices.

Creating additional complications, domestic supply chain security is often affected by external pressures. Ongoing interest in large-scale drug importation programs, such as those involving products from Canada, aim to provide lower-cost medications to American patients. However, any loosening of importation controls or less regulated avenues, like the proliferation of illegal or underregulated online pharmacies from which patients frequently source medications, presents new avenues for unverified products to enter the US market. As a result, patients' ability to trust that their medications will be safe is being undermined.

Strengthening the Supply Chain Through DSCSA

The primary legislative framework governing the security of the US drug supply chain is the Drug Supply Chain Security Act (DSCSA), which was enacted on November 27, 2013, as Title II of the Drug Quality and Security Act. The legislation was intended to supersede disparate state laws and create a single, unified, and interoperable system for tracing chain-of-ownership for prescription medications from the point of manufacture to the point of dispensing (when required by state or federal agents during investigations).

Over the past decade, stakeholders across the supply chain have worked to meet DSCSA requirements, including the serialization of saleable units and homogenous case packaging, and real-time comparison of packaging serialization with manufacturing records to enable product verification.

The final phase of implementation mandated several core requirements, including the following:

- Manufacturers must affix product identifiers (including the Global Trade Item Number [GTIN], a unique serial number, lot number, and expiration date) onto all prescription drug packages using a 2D Data Matrix barcode.
- Trading partners must send and receive data electronically.
- Trading partners must provide transaction information and a transaction statement with each product transfer.
- Product tracing must be conducted to allow authorized agents to gather transaction information in order to create a clear transaction history of ownership.

While DSCSA has succeeded in enhancing serialization and creating a foundation for full electronic tracing, it has been constructed on a decentralized data storage model. In this model, every trading partner, including manufacturers, distributors, repackagers, and dispensers, is responsible for storing their own complete set of serialized transaction data. There is no single national database containing all serial numbers or transaction information.

This decentralized approach presents a significant challenge for the boards of pharmacy and other regulatory bodies. In the event of a drug diversion scheme or a suspected falsified batch, a state board of pharmacy or other regulator must individually query dozens, perhaps hundreds, of trading partners to fully track a suspicious lot or product. This manual, time-consuming process may hinder the rapid, real-time investigations required to quickly remove dangerous products from circulation. Recent state experiences show how access to timely product verification data can make a critical difference in these situations. In absence of live data, patients are put at risk while the data are gathered and any breaks in product traces are resolved.

Responding to Counterfeit Reports in Arkansas, Ohio, and Beyond

In January 2025, the Arkansas State Board of Pharmacy verified a suspect Ozempic product by using the Pulse by NABP™ Product Verification Service (PVS), a free platform for state and federal regulators. An inspector from the Arkansas Board used the Pulse tool on his mobile phone to confirm the illegitimacy of the suspect Ozempic product quarantined at an Arkansas pharmacy within seconds. Utilizing the response from the product verification tool as part of the submitted evidence, the Board launched an investigation of the seller, held an emergency hearing, and suspended the seller's license, which was being used outside of its scope. This incident demonstrates how Pulse can rapidly become an essential tool for US regulators.

Other states have also seen benefits in utilizing the Pulse PVS. In a recent blog post, Jenni Wai, MBA, RPh, chief pharmacist of the Ohio Board of Pharmacy, explained how the technology has helped speed up monitoring for suspect products in the pharmacy supply chain.

"Prior to Pulse PVS, I often had to manually contact the manufacturer and try to get to the right person to conduct a product verification," said Wai. "This process is very time-consuming, and they must verify my credentials to safely provide the information. With Pulse PVS, all parties can be assured that the right person is conducting the verification and that the platform will provide timely results in compliance with the law. Ultimately, we can promptly stop the illegitimate product from being used."

With over 120 state regulators and Drug Enforcement Administration now participating, the platform has already processed over 1,600 product verification requests. Notably, Pulse is positioned to help empower trading partners and regulators to meet their DSCSA obligations and proactively protect patients. The success of this model at the state level underscores the value of centralized, interoperable verification tools and highlights opportunities to apply similar approaches globally.

Scaling Effective Models Beyond US Borders

The deployment of Pulse marks a major milestone in securing the country's domestic supply chain. However, pharmaceutical bad actors often work across national borders. A successful long-term strategy to combat counterfeit and substandard medications will require the seamless adoption of exacting standards and technological tools at a global level.

NABP is committed to leveraging the standards and technology developed for Pulse to fortify supply chains in other parts of the world. This commitment to global security is exemplified by Operation African Star 2, a Pharmaceutical Traceability Pilot Program conducted in East Africa. The initiative demonstrated how the Pulse platform, built to provide a solution for the domestic supply chain, can be equally effective as a complementary communications tool to help other national health regulatory authorities secure supply chains. By establishing interoperable systems grounded in global standards, NABP is building a vital tool with the pharmaceutical industry that can be used against the proliferation of dangerous fake medicines.

The Role of Global Standards and Partnerships

Indeed, securing supply chains worldwide requires shared standards and strong stakeholder partnerships. GS1 global standards, including the use of the GS1 Data Matrix (2D barcode) and GTIN, and electronic messaging standards such as EPCIS and Lightweight Verification Messaging, provide a universal language for product identification and traceability. This enables verification systems such as Pulse to operate consistently across markets and support seamless information exchange. Global traceability also depends on extensive partnerships between public and private entities. NABP is actively seeking collaboration and leadership from industry, donor organizations, government agencies, and the nonprofit sector to help scale verification efforts abroad. The goal is to share the knowledge and tools gained domestically and also evolve the platform for international markets. By supporting the adoption of interoperable systems grounded in global standards, NABP is contributing to a more resilient and transparent supply chain capable of responding to emerging counterfeit threats.

As boards continue implementing DSCSA-aligned practices, technology solutions that support product verification, data access, and interstate collaboration will become increasingly important.

Through ongoing collaboration, NABP and its member boards remain committed to fulfilling regulatory responsibilities, and to strengthening the integrity of the supply chain. More information on Pulse, Operation African Star 2, and related NABP actions will be shared in future communications. ●

Decoding Supply Chain Security: Key Terms Explained

Counterfeit: The most popular term used by the public to describe fake or falsely branded medications.

Suspect and Illegitimate Products: These are the official terms used within the context of the US DSCSA to classify products that may be counterfeit, diverted, stolen, intentionally adulterated, or otherwise unfit for distribution.

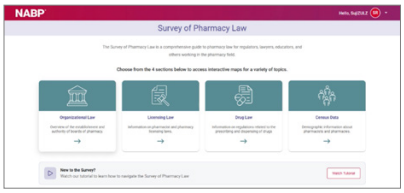
Substandard or Falsified Medication: This is the official terminology used by international bodies like the World Health Organization to describe products that fail quality standards (substandard) or intentionally misrepresent their identity or source (falsified).

Survey of Pharmacy Law Goes Digital in 2026

The 2026 edition of the *Survey of Pharmacy Law* will be available in a new digital format in the first quarter of 2026. As always, the *Survey* provides an overview of the laws and regulations that govern pharmacy practice in all 50 states and three jurisdictions: the District of Columbia, Guam, and Puerto Rico.

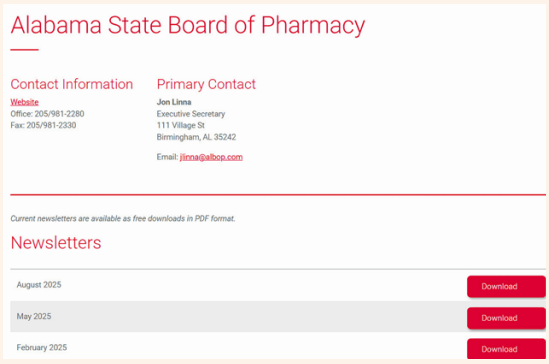
In the new platform, the *Survey* data will still be organized into four chapters: Organizational Law, Licensing Law, Drug Law, and Census Data. The web-based platform provides a new way of viewing and interacting with pharmacy law data. Within the digital platform, each of the *Survey* chapters provides access to the topics in that section and enables users to see how the topics apply to each jurisdiction.

Users can view the data in maps and tables based on the criteria they select. Additionally, the *Survey's* design features explanatory notes of the states' laws within each record. The *Survey* will continue to be updated annually with input from the state boards of pharmacy.



Access to the new digital *Survey* is available as a subscription-based service through the NABP e-Profile® system. For more information, contact help@nabp.pharmacy. ●

State Newsletter Program Section of NABP Website Undergoes Refresh to Improve Navigation



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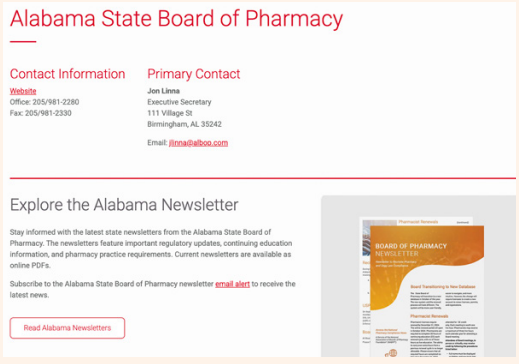

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NABP's State Newsletter Program assists participating boards with publishing state-specific newsletters that convey critical information to pharmacists, pharmacy technicians, and other board licensees. This year, NABP updated the State Newsletter Program section on its website to improve the user experience.

The State Newsletter Program section's new, adapted structure allows for streamlined navigation between newsletters from other participating boards of pharmacy. Instead of clicking multiple separate pages to access a newsletter from a different board, users can navigate to newsletters across multiple states. This web page structure mirrors the structural and organizational changes that were implemented previously on the NABP Reports and Support Center web pages.

Pharmacy professionals can still access the individual board of pharmacy pages in the About section. Additionally, the State Newsletter Program page is also displayed in the navigation bar under the "Newsroom" tab to provide quick access to the page.

These updates were part of NABP's ongoing commitment to offer state boards of pharmacy a convenient way to disseminate critical information to their licensees. NABP periodically updates its website and other communication methods to ensure that licensees and member boards of pharmacy can easily find the information they need.

In 2024, NABP revamped its State Newsletter Program content, offering new options and enhanced services focused on providing more flexibility and streamlining the production process for participating boards of pharmacy.

Visit the relaunched State Newsletter Program section at *https://nabp.pharmacy/state-newsletters*. ●

Missouri Board's Experience Highlights Public Protection Benefits of a 'Just Culture' Approach

Listen | 5:03

When the Missouri Board of Pharmacy began its "just culture" journey 15 years ago, repeat violations were common. Simply issuing discipline letters was not solving the underlying problems, creating what Executive Director Kimberly Grinston, JD, called a "whack-a-mole" effect. So, the Board began looking beyond individual incidents to understand the systemic factors contributing to these repeat errors.

The concept of just culture emerged decades ago to improve safety in high-risk settings where human error is inevitable but can have life-threatening consequences. System design can therefore play a key role in preventing harm. Many boards of pharmacy, including Missouri's, have since adopted this framework to promote transparency and shared accountability around managing and reporting errors, with the end goal of improving patient safety and pharmacist working conditions.

NABP supports the just culture approach as a way to help boards of pharmacy and pharmacist licensees identify behavioral patterns that lead to medication errors and strengthen system safety through continuous learning.

However, implementing a just culture requires both a systems-based approach to error mitigation – examining underlying system issues that contribute to mistakes – and an evaluation of the intent behind human conduct to correct errors. Not all conduct is alike. NABP's Board of Pharmacy Action Decision Tree identifies four categories:

- human quality-related event (ie, honest mistakes);
- at-risk conduct;
- reckless conduct; and
- conduct with bad intent (ie, malicious actions).

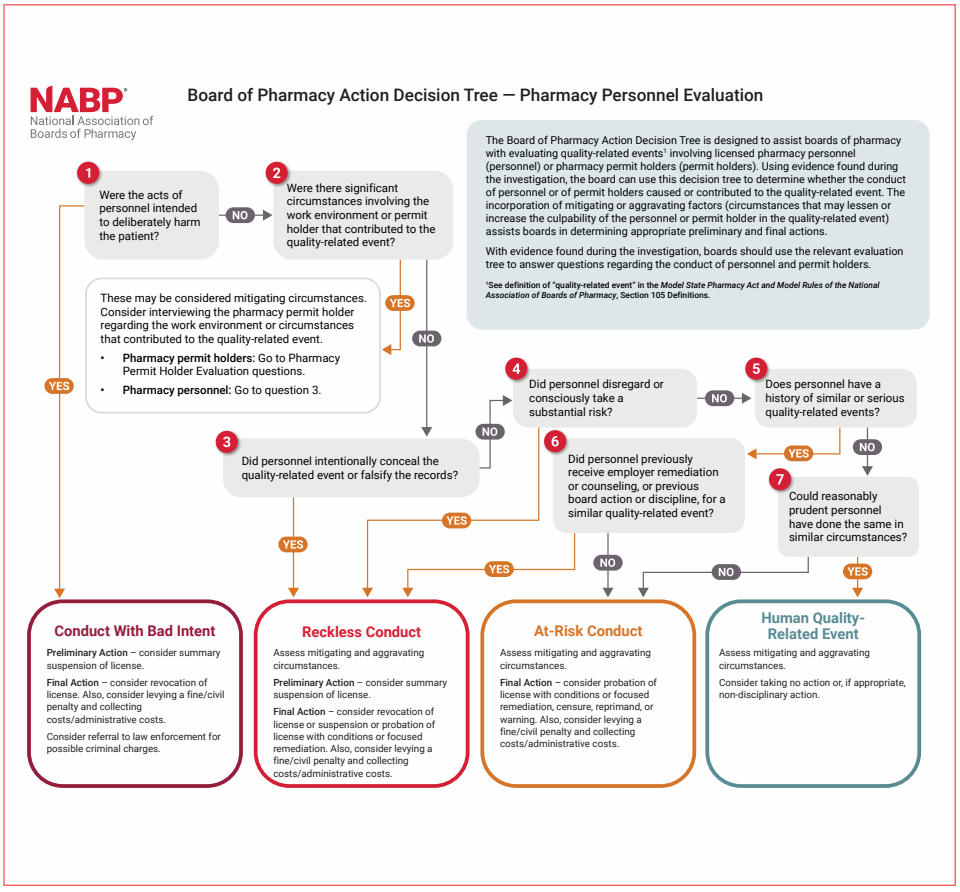
One of the Missouri Board's first steps was training its inspectors to assess cases by using a standardized decision process. Inspectors first reviewed each situation and then discussed findings with the Board. The Board also required all members to become just culture certified and incorporated ongoing education through webinars such as *Lunch with the Chief Inspector*.

Adopting a new approach to culture also required Missouri inspectors to view complaints, investigations, and inspections from a different standpoint. "They needed to change their mindset from 'What did you do wrong?'" said Grinston, "and instead start looking at what happened with the system and ask questions such as, 'What was the intent behind the conduct, and what were the corrective actions around that?'"

When boards of pharmacy assign different consequences to different categories of conduct, they promote better behavior and reporting, according to Grinston. For example, accidentally picking the wrong name from a drop-down list is a different level of error compared to intentionally dispensing a generic drug while billing the name brand. "If you treat both of those as the same thing – if you put both of those people on probation, for example – then it doesn't differentiate the conduct, and it also gives them no incentive to correct or disclose the conduct," she said.

Grinston emphasized that the Board focuses not only on the outcome but on the underlying factors that led to it, for instance, whether a medication error stemmed from system gaps such as a missing Drug Utilization Review (DUR) alert rather than from intentional misconduct.

In this DUR-related scenario, a just culture protects the public by ensuring



"Start looking at what happened with the system and ask questions such as, 'What was the intent behind the conduct, and what were the corrective actions around that?'"

Kimberly Grinston, Executive Director, Missouri Board of Pharmacy

not only that the employee receives action or discipline appropriate to the unintentional conduct, but also that appropriate system changes are made to help prevent future mistakes, like adding a DUR alert or staff training requirements. In this way, "we've actually made the system and patients safer instead of just disciplining the person who made the error," Grinston said.

Once the type of error is identified, the Board determines how best to respond. Education often may be the most appropriate consequence to a human error, depending on the intent behind the conduct. In lieu of discipline, the Missouri Board has sometimes offered licensees the opportunity to take the online state practice exam, review the Institute for Safe Medication Practices safe practice list, or engage in other training to address their knowledge gaps, Grinston said. However, when it comes to intentionally reckless or malicious behavior, the Missouri Board protects the public by making sure those types of conduct are addressed more severely, she said.

Missouri's just culture model has reduced repeat violations and fostered greater accountability among pharmacists and staff, Grinston said.

"Before we started our just culture process, when we found an error, compliance issue, or some type of mistake, we would receive defensive responses that said, 'I don't know what happened, I do my best,' and it was very defensive," Grinston said. "But now when errors come in, they're more likely to say, 'I know what happened. This is the corrective action I've taken. This is how I've retrained staff.'"

Download NABP's Board of Pharmacy Action Decision Tree at *https://nabp.pharmacy/members/board-resources.*

NABP Offers Webinar on Embracing 'Just Culture'

NABP is offering the home study webinar, *Board of Pharmacy Action Decision Tree – A "Just" Approach to Discipline*. This webinar was developed pursuant to a recommendation by the Task Force to Review Unprofessional Conduct and Disciplinary Actions. The Board of Pharmacy Action Decision Tree is intended to assist boards of pharmacy with evaluating quality-related events involving licensed pharmacy personnel or pharmacy permit holders. During this webinar, participants will learn how to utilize this newly developed tool by reviewing various scenarios presented by board executive officers to determine whether licensee conduct is disciplinable and, if so, what type of discipline is appropriate for the situation at hand. Visit the Continuing Education section of the NABP website to learn how to purchase the webinar.

From Discipline to Development: Does Remedial Education Improve Outcomes?

Pharmacists and physicians pledge an oath to apply their attained knowledge and skills to obtain the best outcomes for patients. When health care professionals fail to meet the standards of care, their respective professional licensing boards are responsible for investigating the professional conduct and determining the appropriate course of action to discipline the individuals, whether it is issuing a monetary penalty, revoking or suspending a license, or assigning remedial continuing education (CE) courses. The notion of assigning remedial CE centers on the idea that individuals who analyze and correct their wrongdoing will reduce their likelihood of reoffending. Yet, there are few studies that can prove remedial courses actually reduce recidivism.

Differences Between General and Remedial CE Courses

General CE course curriculum is focused on keeping professionals abreast of the latest developments in their field of study, fulfilling a requirement for that profession, or strengthening existing skills. Remedial courses are designed by third-party educational providers and intended for individuals to analyze the factors that led to their misconduct and form a corrective action plan to not repeat the same action. Each licensing board has its own set of criteria to determine if an individual should be assigned a remedial CE course as opposed to a different disciplinary measure.

Challenges With Measuring Recidivism

Determining how effective remedial courses are in reducing subsequent recidivism is a question that researchers continue to grapple with today.

Only a few studies, such as one conducted by the Center for Personalized Education for Professionals and a study published in *Academic Medicine*, have been able to document the longitudinal effect of remedial courses. The Center for Personalized Education for Professionals, an organization that provides education services and competence assessments to physicians, assessed the long-term effectiveness of an assessment/education intervention while comparing it to stand-alone practice monitoring. According to the study, after an average of 18 months (following the completion of the intervention), physicians who were only assigned practice monitoring "were more than five times more likely to demonstrate care below standard and almost four times more likely to have documentation issues that prohibited the monitor's ability to determine the quality of care" than those who completed the assessment and education intervention prior to practice monitoring. Despite evidence suggesting that combining education with practice monitoring can improve health care professionals' conduct, researchers noted several study limitations, such as the small sample size and lack of access to the type of quality of care physicians offered prior to the process, indicating that further research is needed to validate these findings.

Another study involving medical doctors found similar trends. This study, published in *Academic Medicine*, analyzed a national-level sample of 4,061 medical doctors who were disciplined for the first time between 2011 and 2015. Researchers found that after considering certain circumstances, physicians who were assigned remedial continuing medical education (CME) courses were less likely to receive additional discipline by

Researchers found that after considering certain circumstances, physicians who were assigned remedial continuing medical education courses were less likely to receive additional discipline by state medical boards within five years.

state medical boards within five years. In one method of analysis, controlling for demographic and educational variables, researchers found that of the 1,426 physicians who were subject to additional discipline within five years, 384 (27%) had been assigned remedial CME. While among the 2,635 who were not subject to additional discipline, 1,065 (40%) had been assigned remedial CME.

Researchers also conducted an analysis that considered reasons for the discipline and discipline that included greater limitations on the ability to practice. They concluded that physicians whose first discipline related to CME violations or failure to meet requirements were at a decreased risk of further discipline compared with those whose behavior first merited discipline such as probation. The authors state, "Using remedial CME as a regulatory mechanism for reducing the risk of recidivism shows promise, but regulators should be thoughtful in its application."

Along with the study published in *Academic Medicine*, other studies indicate challenges with quantifying recidivism, highlighting the factors that impact data collection processes. At the state level, the North Carolina Medical Board, for instance, found inconsistencies with data collection – missing data fields, mismatched data, and duplicate entries – in the Board's data collection process after setting out to determine the type of regulatory action that can reduce recidivism among its doctor of medicine and doctor of osteopathic medicine licensees who had one or more prescribing cases.

Similarly, the Washington Medical Commission raised concerns about recidivism data when tracking providers who transferred a license by reciprocity, after they found almost half of those in their study had a subsequent discipline that "stemmed from their failure to comply with the previous discipline order." This scenario is referred to as a reciprocity loop.

The PBI Education organization also discovered a version of the reciprocity loop in their study. The PBI Education organization examined six to 11 years of follow-up data of all participants from California who took PBI's courses on boundaries, ethics, and professionalism between 2010-2014. Of the 210 participants, pharmacists and medical doctors accounted for 85% of the sample. Researchers found that six (2.9%) of the participants committed the same misconduct as their first discipline action, whereas 14 (6.7%) committed a different violation after completing the PBI course. Based on their research, they questioned whether subsequent misconduct should be considered recidivism, given that the new violation may differ from the original offense for which the licensee had already completed appropriate remedial ethics or boundaries training.

Opportunities to Study Remedial CE Courses in Pharmacy Practice

These findings open the door to studying continuing pharmacy education (CPE) courses and whether they can reduce recidivism among pharmacy professionals. Many boards of pharmacy have assigned remedial CPE courses as a form of discipline. Some of them, often in lieu of discipline, treat the assignment as part of a "just culture" approach. For instance, if a pharmacist committed an error, the board may require the pharmacist to take CE courses focused on patient safety and provide evidence (a certificate of completion) back to the board that the course was completed. Boards of pharmacy may note that these courses were considered additional CE and would not be counted toward their licensure renewal. However, as of publication, there are no data available that track the effectiveness of remedial courses by reducing the number of re-offenses in the pharmacy profession.

While further study is warranted, researchers from the North Carolina Medical Board suggested that studying this topic begins with identifying the type of data that need to be captured and maintaining it in a consistent, standard, and validated system. NABP will continue to monitor and report on the latest trends in this area of study once more information becomes available. ●

A Look Back: NABP's Pharmacist Self-Assessment Tool

In 2005, NABP launched the Pharmacist Self-Assessment Mechanism (PSAM), which was part of NABP's Continuing Professional Development program. Viewed as a non-punitive mechanism, the PSAM was seen as a learning tool to help pharmacists reflect on their practice and identify areas for growth. The assessment comprised five components: reflecting upon one's practice, conducting a learning needs assessment, developing a learning plan, implementing the learning plan, and evaluating the learning plan outcomes. Although some boards of pharmacy supported its use for non-Accreditation Council for Pharmacy Education credit, the self-assessment tool was eventually discontinued. ●

Connecting With Your Elected Leaders

Deborah C. Mack, RPh, CHC, CCEP
Executive Committee Member
Member of the Arkansas State Board of Pharmacy

How do you define success?

Success can be defined in so many ways, and the very definition of what makes us feel successful is personal. For me, success was finding a balance between work and personal life, then making a positive impact on others along the way, whether at work or home. At the end of the day, I wanted to feel I did everything possible to enrich the lives of others.

What is the best job decision you ever made?

My best job decision was to become a pharmacist. I knew I would follow in my dad's footsteps from a young age. That is where my heart was and where my career started. Then, being a pharmacist made everything else possible. When you love your work, it doesn't feel like work.

What is the best piece of advice you've ever been given?

Early in my pharmacy career, I was told you can achieve anything you want in pharmacy if you look for the opportunities. Being a pharmacist was my base. Each step in my career was something new and challenging, all the way from practicing in a pharmacy to overseeing the operations of many pharmacies, and then to regulatory affairs in multiple states, where it amazed me how differently each state regulates the profession.

Matthew R. Martineau, PharmD, RPh
Executive Committee Member
Executive director of the Wyoming State Board of Pharmacy

What is the best piece of advice you've ever been given?

One of my community pharmacy rotations as a pharmacy intern was in a tourist destination. More than once, I was told by an angry patient that I had ruined an entire family vacation. My preceptor shared a slightly different version of Hanlon's razor with me: "Never attribute to malice that which can be explained by ignorance." He reminded me that our patients aren't out to hurt us. They may not be feeling well, they may be acting from their own limited experience or knowledge of our health care system, and other circumstances may be contributing to their outburst. It doesn't excuse harmful or abusive behavior, but his outlook has helped me respond to challenging situations by discouraging assumptions.

Which living person do you most admire?

I greatly admire, respect, and appreciate my wife, Elizabeth. Particularly, her composure, thoughtfulness, and ability to communicate complex ideas with clarity. She's an incredible partner, and she constantly challenges me to be better.

What did you learn from your biggest failure or disappointment?

Failure, as they say, is the greatest teacher. Failure and setbacks teach us information that we can't really learn any other way. We can fail, even when we've done everything "right." Failure can be because of our own actions, our colleagues, or the entire team. Learning *how* to analyze a past event – identify strengths and weaknesses, document lessons learned, and provide recommendations for future improvements – has helped teach me humility, resilience, and to "get back on the horse," as my grandpa would have said.

Stay tuned for more behind-the-scenes insights in future issues, when we will have an opportunity to hear from other NABP Executive Committee members.

Executive Officer Changes

- **Jon Linna, RPh,** has been named executive secretary of the Alabama State Board of Pharmacy. Most recently, Linna was director of pharmacy operations for a privately owned pharmacy that provides pharmacy services, consulting, and education to skilled nursing facilities, assisted living communities, and other residential communities in the Southeast. He received a bachelor of science degree in pharmacy from Auburn University.
- **Aaron Patterson, PharmD, RPh,** has been appointed executive director of the Minnesota Board of Pharmacy, succeeding the retiring director, Jill Phillips, MPH, RPh. Patterson is an experienced member of the Board's staff, having most recently served as the interim director since February 2025. Prior to that, he was a pharmacy surveyor for the Board, a position he held since 2017. Before his tenure with the Board, Patterson practiced pharmacy and held licenses in multiple Midwestern states, where he was engaged in sterile and nonsterile compounding, home care, and community pharmacy activities. He earned his doctor of pharmacy degree from Drake University.

Board Member Appointments

- **Melinda Browning, MS, CPhT,** has been appointed a member of the Arizona State Board of Pharmacy. Browning's appointment will expire on January 21, 2030.
- **Walter Lyn Fruchey, PharmD, RPh,** has been appointed a member of the Arkansas State Board of Pharmacy. Fruchey's appointment will expire on June 30, 2030.
- **Janine Ohler, PharmD, RPh, BCPS,** has been appointed a member of the Kansas State Board of Pharmacy. Ohler's appointment will expire on April 30, 2029.
- **Brian D. Banks, MA,** has been appointed a public member of the Maryland Board of Pharmacy. Banks' appointment will expire on September 30, 2029.
- **Marisol De Leon, MBA, PharmD, RPh,** has been appointed a member of the Maryland Board of Pharmacy. De Leon's appointment will expire on September 30, 2029.
- **M. Amir Masood, PharmD, RPh,** has been appointed a member of the Maryland Board of Pharmacy. Masood's appointment will expire on April 30, 2028.
- **Matthew Shimoda, PharmD, RPh,** has been appointed a member of the Maryland Board of Pharmacy. Shimoda's appointment will expire on August 31, 2029.
- **Jana Rasmussen** has been appointed a public member of the Minnesota Board of Pharmacy. Rasmussen's appointment will expire on January 4, 2027.
- **Patsy "Patti" Hawkins, PharmD, RPh,** has been appointed a member of the Mississippi Board of Pharmacy. Hawkins' appointment will expire on June 30, 2030.
- **Michelle Case, CPhT,** has been appointed a member of the Montana Board of Pharmacy. Case's appointment will expire on July 1, 2027.
- **Logan Tinsen, PharmD,** has been appointed a member of the Montana Board of Pharmacy. Tinsen's appointment will expire on July 1, 2026.
- **William L. Irvin, RPh,** has been appointed a member of the New Hampshire Board of Pharmacy. Irvin's appointment will expire on September 6, 2026.
- **Amanda L. McClellan, CSPT, CPhT-Adv,** has been appointed a member of the New Hampshire Board of Pharmacy. McClellan's appointment will expire on September 7, 2027.
- **Larry N. Meek, RPh,** has been appointed a member of the South Carolina Department of Labor, Licensing, and Regulation – Board of Pharmacy. Meek's appointment will expire on June 30, 2031.
- **Jarrod B. Tippins, PharmD, RPh,** has been appointed a member of the South Carolina Department of Labor, Licensing, and Regulation – Board of Pharmacy. Tippins' appointment will expire on June 30, 2031.

MILESTONE

In October 2025, the Association hosted the 15th NABP Forum, which for the first time brought together members from all four forum groups – executive officers, compliance officers, legal counsel, and board members – during the same week. The 2025 NABP Forum also saw a wide representation of member jurisdictions, with 43 states and jurisdictions represented by at least one of the attendee groups. Attendees continue to value the forum for the unique opportunity it provides to have open, insightful dialogue about common challenges faced by the boards across all jurisdictions, as well as space to develop solutions.

Join Your Colleagues at the 122nd Annual Meeting, Where We Will Be *Illuminating Regulatory Paths Together*

The meeting will be held at the Hilton Boston Park Plaza, 50 Park Plaza at Arlington Street, Boston, MA, 02116. When making your travel plans, please note that the first events begin on Tuesday, May 12, and the last event ends on Friday, May 15. Visit the **122nd NABP Annual Meeting** website for more information and to register. Early registration rates end on February 28, 2026. ●

Executive Committee Candidate Qualifications

- Must be an affiliated member (administrative officer or board member) of the Association currently serving on an active member board of pharmacy at the time of nomination and election
- Must not currently serve as an officer, official, or board or staff member for any national or state pharmacy organization
- Must not have a conflict of interest with the purpose, mission statement, and operation of NABP

More information about the procedures for nominating and electing Executive Committee officers and members is available in Article IV, Sections 3(b) and 3(c) of the NABP Constitution and Bylaws. ●

NABP Announces 2026-2027 Executive Committee Candidates; Elections to Take Place During Annual Meeting

At the time of this issue's publication, NABP has received the following nominations for the open Executive Committee officer and member positions:

President-elect (one-year term)	Shane R. Wendel, PharmD, RPh
Treasurer (one-year term)	Kamlesh "Kam" Gandhi, PharmD, RPh
District 3 Candidate (three-year term)	Christopher P. Harlow, PharmD
District 4 Candidate (three-year term)	Steven W. Schierholt, Esq
District 8 Candidate (three-year term)	Lorri Walmsley, RPh, FAzPA

Updates to the list of nominations will be posted on the Annual Meeting page in the Meetings section of www.nabp.pharmacy.

Individuals interested in running for an open officer or member position must submit a letter of intent, including the expiration date for their term on an active member board, and a résumé or curriculum vitae to the NABP executive director/secretary at least 45 days prior (by March 29, 2026) to the Annual Meeting. ●

Proposed Resolutions Will Be Distributed in February

Proposed resolutions received at NABP Headquarters by Friday, February 6, 2026, will be distributed electronically to the state boards of pharmacy on the following Thursday, February 12, 2026, for review prior to the 122nd NABP Annual Meeting. This mailing will constitute the only preconference distribution of proposed resolutions. All resolutions – those distributed for early review as well as those received after February 6 – will be presented to the voting delegates during the Second Business Session of the Annual Meeting by the chair of the Committee on Resolutions and subsequently voted on during the Final Business Session.

Any active member board, district, or committee of the Association may submit resolutions to NABP. To be considered during the Annual Meeting, resolutions must be received by Thursday, April 23, 2026, in accordance with Article IV, Section 6, Part (d) of the NABP Constitution and Bylaws. Resolutions not submitted at least 20 days prior to the Annual Meeting but submitted within a time frame that the Executive Committee deems appropriate (prior to the meeting of the Committee on Resolutions) may be presented during the Annual Meeting and will be considered for adoption by the Association upon the affirmative vote of three-fourths (3/4) of those active member boards present and constituting a quorum.

Questions regarding resolution procedures should be directed to the NABP Executive Office via email at ExecOffice@nabp.pharmacy. NABP has created a video that provides tips on drafting resolutions and how to submit them. ●

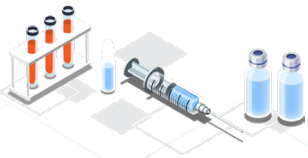
Pre-Meeting Deadlines

- **Early Annual Meeting Registration Rate**
  Ends February 28, 2026
- **Standard Annual Meeting Registration Rate**
  Begins March 1, 2026;
  Ends April 30, 2026
- **Last Call Annual Meeting Registration Rate**
  Begins May 1, 2026;
  Ends May 15, 2026
- **Proposed Constitution and Bylaws Amendments**
  Due March 29, 2026
- **Proposed Resolutions**
  Due April 23, 2026 ●

Submit Proposed CBL Amendments by March 29

To be considered during the 122nd NABP Annual Meeting, proposed amendments to the NABP Constitution and Bylaws (CBL):

- **must be submitted between February 12, 2026, and March 29, 2026** (per the current CBL, proposed amendments will be accepted no earlier than 90 days and no later than 45 days before the First Business Session of the Annual Meeting);
- may be proposed by any active member board of pharmacy, the NABP Executive Committee, or the Committee on Constitution and Bylaws; and
- must be submitted, in writing, to NABP Executive Director/Secretary Lemrey "Al" Carter at ExecOffice@nabp.pharmacy. ●



Share Your Research With Regulatory Peers as Part of the

Annual Meeting Educational Poster Session

Poster proposals must meet the guidelines and be submitted using the online form by

Wednesday, February 4, 2026

POSTERS MAY BE

Descriptive, Scientific, or Informational in Nature

and will not be judged.

When preparing your poster proposal, please ensure that the following requirements are met:

- Submit your proposal via the online proposal submission form.
- Include a summary of the poster's topic and how it relates to the Educational Poster Session theme, "Illuminating Public Health Protection."
- Include the poster title and list the name, degree, and title of the individual(s) who will present the poster.
- Posters should be non-promotional, unbiased, and politically neutral in nature.

Details regarding the above requirements are provided in the *Educational Poster Session Proposal Submission Guidelines* document. Please review it carefully to ensure your proposal complies with the requirements.

The Educational Poster Session will take place on the last morning of the 122nd NABP Annual Meeting on **Friday, May 15, 2026, from 8:30–10 AM EDT**.

Presenters must be able to attend the in-person meeting at **7:30 AM EDT on Friday, May 15, 2026**, and be available in March and April for correspondence with NABP staff. Can't make it to Boston? Proposals are also being accepted for the Poster Presentations webinar on **Thursday, June 11, 2026, from 2–3:30 PM EDT**.

We look forward to learning about your research.

Presenters will receive complimentary registration and may be eligible to earn Accreditation Council for Pharmacy Education (ACPE)-accredited continuing pharmacy education (CPE) credit. Pharmacy student presenters also receive a Pre-NAPLEX® voucher.

NABP
National Association of Boards of Pharmacy

NABP and the NABP Foundation® are accredited by ACPE as providers of CPE. ACPE provider number: 0205. Details about Annual Meeting CPE programming are available at *http://NABPannualmeeting.pharmacy*.

Interested in Serving on a 2026-2027 Committee or Task Force? Applications Now Open

NABP is seeking volunteers from its active member boards of pharmacy to serve on its 2026-2027 committees and task forces. Executive officers and current board members, including public members, interested in serving on a committee or task force are encouraged to apply and submit an up-to-date résumé or curriculum vitae. Affiliated members from associate member boards of pharmacy and board of pharmacy staff interested in volunteering for NABP task forces are also encouraged to apply.

Please apply online by May 15, 2026. All materials will be forwarded to NABP President-elect Nicole L. Chopski, PharmD, ANP, who will make the appointments following the 122nd NABP Annual Meeting.

STATE BOARD NEWS

Dispensing CS and Veterinary Prescription Guidance

Idaho No Longer Requires 'Certification of No Dispensing of Controlled Substances' Form for RDOs, NDOs, and PDOs

The Idaho Division of Occupational and Professional Licenses is no longer requiring a Certification of No Dispensing of Controlled Substances form for the following Idaho-licensed or -registered drug outlets: Resident Drug Outlets (RDOs), Non-Resident Drug Outlets (NDOs), and Prescriber Drug Outlets (PDOs).

According to Idaho Statute 37-2730A(1) Prescription Tracking Program, "data collected pursuant to this subsection shall be reported by the end of the business day by all drug outlets that dispense controlled substances in or into Idaho for human patients." With the implementation of the new licensing system (Oasis), specific questions have been added to the initial and renewal applications, removing the need for the form.

New Mexico Implements Changes to Custodial Care Facilities' Responsibilities

In New Mexico, custodial care facilities can now stock opioid antagonists (rather than naloxone specifically) and epinephrine auto-injectors. According to the legislation, a custodial care facility is defined as "any facility which provides care and services on a continuing basis, for two or more in-house residents, not related to the operator, and which maintains custody of the residents' drugs." The updates to New Mexico Administrative Code 16.19.4.11 will allow greater flexibility and availability of stock medication in custodial facilities.

Utah's New Toolkit Aids Pharmacists in Managing CS

The Utah Controlled Substance Database Program released the Utah Controlled Substances Toolkit to aid health care providers in managing controlled substances (CS). The toolkit's platform allows for straightforward navigation to trusted and up-to-date resources, such as best practices, patient education materials, prescribing guidelines, and Utah-specific CS laws. The toolkit is available at *cstoolkit.utah.gov*.

Missouri Board Reminds Pharmacists About Filling Veterinary Prescriptions

The Missouri Board of Pharmacy is reminding pharmacists to refer to their procedures for adding veterinarians (who do not have a Drug Enforcement Administration [DEA] registration number) to their computer database. Veterinarians are not obligated to have a DEA registration to prescribe non-controlled medications. This reminder follows an incident where a Missouri-licensed veterinarian claimed a pharmacy refused to fill a non-CS prescription because the veterinarian lacked a DEA registration number and was not found in the pharmacy software system.

North Carolina DHHS Provides Guidance on Reporting Veterinary Gabapentin Dispensing

Last year, the North Carolina Department of Health and Human Services (DHHS) announced a state license failover for veterinary gabapentin reporting in the NC Controlled Substances Reporting System (CSRS). As of March 1, 2025, state law requires reporting all veterinary dispensations of gabapentin to the CSRS. The failover allows veterinarians who do not have a DEA or National Provider Identifier number to still be able to submit CSRS reports of veterinary gabapentin dispensations by using the veterinarian's NC license number. The NC DHHS Drug Control Unit published updated dispenser and veterinarian dispenser guides, along with a frequently asked questions document for gabapentin veterinary state license failover reporting.

NABP
National Association of Boards of Pharmacy

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Mount Prospect, IL 60056

UPCOMING EVENTS

Committee on Law Enforcement/Legislation
March 2-3, 2026 | NABP Headquarters

Advisory Committee on Examinations
March 10, 2026 | NABP Headquarters

Committee on Constitution and Bylaws
April 6, 2026 | Virtual Meeting

122nd NABP Annual Meeting
May 12-15, 2026 | Boston, MA

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